

# Oversight Division

C o m m i t t e e   O n   L e g i s l a t i v e   R e s e a r c h

## Program Evaluation of Medicaid Fraud Program

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# Program Evaluation of Medicaid Fraud Program

***Prepared for the Committee on Legislative Research  
by the Oversight Division***

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***Review Team:***

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***February, 2000***

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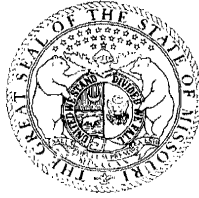
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STATE CAPITOL  
JEFFERSON CITY, MISSOURI 65101-6806

February, 2000

Members of the General Assembly:

As authorized by Chapter 23, RSMo, the Committee on Legislative Research adopted a resolution on June 9, 1999 directing the Oversight Division to perform a program evaluation of the State Medicaid Fraud Program which included the examination of records and procedures in the Department of Social Services and the Office of Attorney General to determine and evaluate the fraud program performance in accordance with the program's objectives, responsibilities, and duties as set forth by statute or regulation.

The accompanying report includes Oversight's comments on internal controls, compliance with legal requirements, management practices, program performance and related areas. We hope this information is helpful and can be used in a constructive manner for the betterment of the state program to which it relates.

Respectfully,

A handwritten signature in black ink, appearing to read "Robert M. Clayton III".

Representative Robert M. Clayton III  
Chairman

## EXECUTIVE SUMMARY

The Medicaid Program in Missouri is a federal and state funded program that provides health care for children, adults and families based on income level and medical or physical conditions. Managed by the Department of Social Services, Medicaid is one of the largest state programs in Missouri. In state fiscal year 1999, the program served more than 683,000 Missouri residents, or 13 percent of the state's population. Total medical expenditures, including mental health and developmental disabilities services, were about \$2.9 billion in state fiscal year 1999. Of this amount, federal funds supported 60% and state funds supported 40%.

The magnitude of expenditures and volume of services increase the risk of Medicaid fraud. Fraud is an intentional deception or misrepresentation resulting in an unauthorized benefit, such as when a provider intentionally bills Medicaid for a service that it did not provide or for services that were not necessary.

Oversight's evaluation of the Medicaid Fraud Program in Missouri covering periods from July 1, 1994 through June 30, 1999, indicated the program is not meeting expectations. When the Medicaid Fraud Unit was created through legislation passed in 1994, the Attorney General's Office estimated that an average of \$10 million annually would be recouped through court cases related to Medicaid payments being received fraudulently. Using the same average, the total state share of these collections (40%) during the evaluation would have been \$20 million; however, the actual state share of Medicaid fraud collections by the unit totaled only \$4.2 million, of which \$3 million resulted from a national Medicaid settlement in 1994.


The Attorney General's Office did not fully staff the Medicaid Fraud Control Unit. Even though the General Assembly has appropriated funds for 23 full time employees, the Unit is only staffed with 13 full time employees. Fully staffing the unit could result in increased collections and gaining federal matching funds for staff.

During the evaluation, Oversight determined that the Office of Attorney General did not promptly investigate all cases in a timely manner as required by their memorandum of understanding with the Department of Social Services. In fact, in twelve of twenty-five complaint files reviewed no preliminary or follow-up action had been taken for a period of up to two years before the cases were investigated or closed. In two of the files that were closed, the cases were not referred back to the Department of Social Services for further action. Oversight recommends all referrals to the Attorney General's Office be reviewed within 90 days. If the Attorney General elects not to file charges against the provider, the case should be forwarded back to the Department of Social Services for recoupment of any overpayments or other action. Oversight also noted that the Attorney General has not been requesting reimbursements for all investigation and prosecution costs from Medicaid providers convicted of fraud as allowed by statute. The AG's Office lacked documentation of prosecution costs in their case files. Such reimbursements would help fund the effort to combat Medicaid fraud in Missouri.

The Department of Social Services should develop an overall framework to heighten accountability for fraud detection and prevention in the state Medicaid program. As part of the Department's strategic plan, the Medicaid program needs to evaluate how its resources are deployed, determine whether resources should be redistributed to increase their fraud- and abuse- fighting potential, and whether additional resources are needed. Although the General Assembly provided funding for five additional staff to assist the Medicaid Fraud Control Unit, the Department has not filled two of the positions. Staff in their Surveillance and Utilization Review Unit may not be adequately trained in fraud prevention and detection. Oversight recommends the Department of Social Services fill the remaining two positions with qualified staff, such as certified fraud examiners. They should also provide training in fraud prevention and detection to increase the effectiveness of the unit.

It should be noted that our review concentrated on the start-up phase in the Medicaid Fraud Control Unit within the Attorney General's Office. According to AGO management, recent reorganization of that unit should result in a more responsive effort to combat Medicaid fraud in the state. We focused our review on the investigation and prosecution of fraud in the Medicaid system and did not review the prosecution of abuse and neglect in the nursing home setting.

We acknowledge the cooperation and assistance of the staff of the Department of Social Services and Office of Attorney General during our evaluation.



Jeanne Jarrett, CPA  
Director, Oversight Division

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## Chapter 1 - Introduction

The Joint Committee on Legislative Research directed the Oversight Division to conduct a program evaluation of the State Medicaid Fraud Program within the Department of Social Services and the Office of Attorney General. The evaluation review had the following components: to determine the effectiveness of the fraud programs, the benefits of the program in relation to expenditures, the goals of the fraud program, the development of indicators by which the success or failure of the program may be gauged, the conformity of the program with legislative intent, and the impact of any federal grant programs on the program.

## Background

### The Federal Medicaid Program in Missouri

Medicaid is a federal- and state-funded program that provides health care for children, adults, and families based on income level and medical or physical conditions. Managed by the Department of Social Services - Division of Medical Services, the Medicaid program is one of the largest state programs in Missouri. In Fiscal Year 1999, the Medicaid program served more than 683,000 Missouri residents, or 13 percent of the State's population. Medical expenditures for all services, including mental health and development disabilities services (which are overseen by the Department of Mental Health) were about \$2.9 billion in Fiscal Year 1999, of which 60 percent was federally funded and 40 percent was state general funded.

In Missouri, as in other states, Medicaid is a program whose growth continues. Over the past six years, Medicaid expenditures at DOS have increased by approximately \$1.1 billion, or 56 percent. Expenditures have increased because the program serves more eligibles with serious illnesses, such as people who are elderly or disabled. The increase in recipients has occurred primarily in population groups that are less costly to serve, such as adults and children on welfare, due to an expansion of Medicaid coverage to a broader range of children in Fiscal Year 1999.

During Fiscal Year 1999, the Missouri Medicaid Management Information

System (MMIS) processed about 46.2 million Medicaid claims on behalf of Medicaid recipients. These claims covered a comprehensive package of health care services including nursing facilities, hospitals, dental services, prescription, physician, in-home services, mental health services, and managed care.

The magnitude of expenditures and volume of services increase the risk of Medicaid fraud. Fraud is an intentional deception or misrepresentation resulting in an unauthorized benefit, such as when a provider intentionally bills Medicaid for a service that it did not provide for services that were not necessary.

Since Medicaid programs pay health care providers directly, fraudulent and abusive financial practices occur predominantly among providers rather than among Medicaid recipients. There are many types of providers, such as physicians, pharmacies, hospitals, clinics, home health agencies, nursing homes, laboratories, and therapists. Nationally, fraud and abuse schemes have been perpetrated or executed by every provider type. Some of the examples listed below demonstrate some of the types of fraud schemes executed in various states around the nation during the past five years. The dollars lost to these schemes have been significant.

A physician billed for two patient office calls even though only one took place, billed for office visits even though the patient missed the appointment, or billed for visits even though the office was closed or the physician was not in the office.

A provider billed for expensive custom-made orthotics but provided the recipient with less expensive stock goods.

A nursing facility billed and was paid by Medicaid for services allegedly provided to a resident after the resident had died.

A laboratory billed for each test separately instead of charging one combined, lower fee, as was appropriated (unbundling).

A provider retained its Medicaid overpayments rather than refunding them to Medicaid.

A recipient received a kickback from a physician to use the recipient's Medicaid number to bill for services the physician did not provide.

Federal and state governments are concerned about the growth of Medicaid fraud and abuse. The U. S. General Accounting Office (GAO) testified as follows regarding the proliferation of fraud and abuse in Medicare and Medicaid programs nationwide:

"In summary, our work clearly demonstrated that Medicare - - serving the elderly and disabled - - and Medicaid - - serving the poor - - are overwhelmed in their efforts to keep pace with, much less stay ahead of, profiteers bent on cheating the system. Various factors converge to create a particularly rich environment for profiteers. For both programs, these include the following:

Strong incentives to over provide services.

Weak fraud and abuse controls to detect questionable billing practices.

Few limits on those who can bill.

Little chance of being prosecuted or having to repay fraudulently obtained money."

[Nationally], Medicaid spent about \$143 billion (of which \$81 billion was federal aid) on behalf of 34 million recipients during fiscal year 1994. Its size, structure, target population, and state-by-state variations render the program especially vulnerable to false billings and other fraudulent activities." (Source: Medicare and Medicaid, Opportunities to Save Program Dollars by Reducing Fraud and Abuse, United States General Accounting Office Testimony Before the Subcommittee on Human Resources and Intergovernmental Relations, Committee on Government Reform and Oversight, House of Representatives, March 2, 1995.)

The cost of fraud and abuse in Medicare and Medicaid programs is difficult to estimate, although state and federal agencies have attempted to do so. Many of these estimates have been controversial. However, recent studies using statistically valid samples have provided more reliable estimates. For example, the Office of Inspector General (OIG) at the U. S. Department of Health and Human Services estimated that, due to recent efforts to reduce Medicare fraud and abuse, the number of inappropriate Medicare payments has decreased to about 7.1 percent of claims. The federal government has estimated that at least ten percent of the nation's Medicaid expenditures (nearly \$16 billion) could be

avoided if waste, fraud, and abuse were identified and eliminated.

The federal Health Care Financing Administration (HCFA) requires that all Medicaid programs have ongoing fraud and abuse detection activities carried out by staff trained specifically to detect fraud and abuse related to Medicaid health care services. In Missouri, the Medicaid fraud and abuse prevention, detection, and recovery is mainly the responsibility of the staff at the Department of Social Services, the single state agency that administers the Medicaid program, and the Office of Attorney General's Medicaid Fraud Control Unit.

At the Department of Social Services (DOS), the duties of the of the Division of Medical Services - Division of Medical Services - Surveillance, Utilization Review Unit include reviewing fee-for-service providers' billings for allowability. The Unit applies historical standards established by the federal Health Care Financing Administration and reviews about 80 of 16,000 providers per quarter, or about two percent of providers per year. The Unit selects providers for review through one of two methods: 1) referrals (the Unit reviews 100 percent of referrals received) and 2) analysis of claims to identify aberrant claims or "outliers." Once a provider is selected for review, it may receive either a desk (in-office) or field (on-site) review. If the review determines erroneous payments were made, the Department can request a refund of monies and impose sanctions against the provider. If the Unit determines that fraud may be involved, it refers the case to the Office of Attorney General - Medicaid Fraud Control Unit. The Surveillance, Utilization Review Unit recovered \$590,882 in Fiscal Year 1999, \$526,216 in Fiscal Year 1999, \$494,405 in Fiscal Year 1997, \$359,443 in Fiscal Year 1996, and \$272,960 in Fiscal Year 1995.

In Missouri, Medicaid services are delivered and reimbursed by either a fee-for-service payment system or managed care plan. Fee-for-service payment systems present risks that providers will deliver more services than necessary or bill for services they did not provide. Managed care presents risks that providers will deliver fewer services than appropriate to reduce costs and retain profit. Under both fee-for-service and managed care systems, there are opportunities for providers to abuse the system at the expense of taxpayers and recipients. As the managed care system for delivering health care services continues to evolve, those in the health care industry, as well as the Medicaid program, will continue to identify ways that fraud and abuse are committed and- more importantly-how those practices can be detected and prevented.

## **BACKGROUND ON MEDICAID FRAUD CONTROL UNIT**

The Medicaid Fraud Control Unit (MFCU) is organizationally located within the Public Safety Division of the Office of Attorney General. The MFCU was first certified by the U. S. Department of Health and Human Services on January 1, 1995. The MFCU employed thirteen staff members as of August 27, 1999. The MFCU is managed by a director who is assisted by a chief investigator who supervises the day-to-day activities of the investigators.

The MFCU receives case referrals from the Surveillance and Utilization Review Unit (SURS) of the Department of Social Services (DOS) - Division of Medical Services and from the Medicaid Investigations Unit in the DOS - Division of Legal Services. The MFCU and DOS operate under a Memorandum of Understanding. In addition, the MFCU receives referrals and complaints from the Health Care Finance Administration of the U. S. Department of Health and Human Services. A complaint or referral is closed after it has been investigated and determined to have no prosecution merit. However, if a complaint or referral has prosecution merit, an active case is opened and assigned to an attorney for appropriate legal action. Investigators are assigned to assist attorneys within the MFCU. The MFCU also employs an auditor and a registered nurse to assist the attorneys and investigators in the prosecution of cases.

The MFCU attorneys prosecute cases in both state and federal courts. Cases are commonly referred for prosecution to both local prosecutors and to U.S. Attorney Offices for the Eastern and Western Districts of Missouri. Two attorneys within the unit are Special Assistant United States Attorneys for the Eastern District of Missouri which enables the MFCU to prosecute health care fraud on the federal level.

This evaluation reviewed the fraud and abuse activities related to health care delivered under a fee-for-service system and a managed care approach. In Fiscal Year 1999, fee-for-service and managed care accounted for about \$2.9 billion of Missouri Medicaid program expenditures managed by the Department of Social Services. This includes the types of services and programs listed in the following table.

OVERSIGHT DIVISION  
Program Evaluation  
Medicaid Fraud Program

Nursing Facilities	\$715,053,894
Hospitals	\$518,471,036
Dental Services	\$6,039,293
Pharmacy	\$468,598,432
Physician Related	\$142,998,872
In-Home Services	\$160,785,429
Other Services	\$59,764,714
Buy-in Premiums	\$49,113,673
Mental Health	\$241,910,746
State Institutions	\$136,813,414
EPSDT Services	\$ 89,218,520
Managed Care	\$307,342,648
Total	\$2,896,110,673

During the evaluation, Oversight utilized Medicare and Medicaid experience in other states to review the Missouri Medicaid program's effectiveness in preventing fraud and abuse. Oversight reviewed the program's policies and procedures for preventing and recovering inappropriate payments. Missouri's practices were compared to federal agencies' studies and other states that have aggressive programs for preventing fraud and abuse - primarily federal Department of Health and Human Services and the state of Florida for provider agreements.

## **Objectives**

The evaluation had the following components: to determine the effectiveness of the program, the benefits of the program in relation to expenditures, the goals of the program, the development of indicators by which the success or failure of the program may be gauged, the conformity of the fraud program with legislative intent, and the impact of any federal grant programs on the program.

## **Scope/Methodolgy**

The scope of the evaluation review concentrated on the effectiveness and efficiency of the detection and prevention within the State Medicaid Fraud Program for the time period of July 1, 1994 through June 30, 1999. The methodology used by the Oversight Division included tests of samples of transactions and evaluations of management controls to the extent necessary to fulfill evaluation objectives. A primary method used to measure objectives was conducting personal interviews with agency personnel. Additionally, the evaluation included performing on-site testing of controls and procedures.

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## Chapter 2 - Medicaid Fraud Control Unit

### Comment #1

**The Office of Attorney General - Medicaid Fraud Control Unit did not promptly investigate all cases in a timely manner as required by the Memorandum of Understanding between the two agencies.**

Effective April, 1997, the Office of Attorney General - Medicaid Fraud Control Unit (MFCU) and the Department of Social Services (DOS) - Division of Medical Services - Surveillance Utilization Review Unit (SURS) signed a memorandum of understanding (MOU) setting forth both parties' responsibilities pursuant to the federal requirements for participation in the federal Medicaid Fraud Control Unit Program. The MOU states the MFCU will screen all suspected fraud referrals from DOS within 90 days to determine whether the further investigation for potential fraud is warranted.

Oversight selected twenty-five complaint files for review from the listing of complaints filed with the MFCU. Oversight noted that in twelve of the twenty-five complaint files reviewed no preliminary or follow-up action had been taken for a period of up to two years before the cases were investigated and closed. MFCU stated that some cases sat for a period of time before they were closed because MFCU had higher priority cases to investigate.

If the MFCU were to review all suspected fraud referrals within the required ninety days they would possibly increase the state's chances of locating witnesses and successfully prosecuting cases. In addition, chances of recoupment would likely be better.

Oversight recommends the General Assembly encourage the MFCU to adhere to the requirements of the memorandum of understanding for reviewing all referrals within 90 days. In addition, when MFCU

closes a referral they should notify SURS of the action taken and allow SURS to investigate the case for any administrative actions that could be taken.

## **Comment #2**

**The Office of Attorney General - Medicaid Fraud Control Unit closed referrals for further investigation but did not refer them back to the Department of Social Services - Division of Medical Services - Surveillance Utilization Review Unit for review and follow-up for any overpayments or billing mistakes.**

Effective April, 1997, the Office of Attorney General - Medicaid Fraud Control Unit (MFCU) and the Department of Social Services (DOS) - Division of Medical Services - Surveillance Utilization Review Unit (SURS) signed a memorandum of understanding (MOU) setting forth both parties' responsibilities pursuant to the federal requirements for participation in the federal Medicaid Fraud Control Unit Program. The MOU states that a Liaison Committee, made up of DOS and MFCU staff, shall meet periodically as necessary, but no less than monthly. The duties of the Committee shall include reviewing all referrals, potential referrals, requests for information, the two agencies' need for cross-training, and other matters pending between them. The Committee is no longer meeting monthly. They are only meeting when one or both of the agencies determine a meeting is necessary. The MOU also states the MFCU will screen all referrals from DOS in matters in which SURS suspects fraud within 90 days to determine whether the case requires further investigation for potential fraud. In addition, on a monthly basis the MFCU is to inform DOS of those providers it has under investigation and will consult with DOS with respect to the activities of such providers.

Oversight selected twenty-five complaint files for review from the listing of complaints filed with the MFCU. Oversight noted two cases that were closed by MFCU but not referred back to SURS for further action. Further investigation by Oversight revealed that subsequent to the referral to MFCU by SURS, the state

paid these providers \$62,440 for Medicaid claims.

MFCU and SURS indicated to Oversight the monthly committee meetings have been discontinued due to the lack of new agenda items. Meetings are scheduled on an as-needed basis between MFCU and SURS. The lack of communication between MFCU and SURS on closed cases by MFCU has resulted in payments being made to providers who may have been overpaid or are billing incorrectly.

Oversight recommends the General Assembly encourage the MFCU and SURS to adhere to the requirements of the memorandum of understanding between the two agencies or amend the memorandum to reflect current procedures. In addition, when MFCU closes a referral for further investigation, MFCU will notify SURS of the action taken and allow SURS to investigate the case for any administrative actions that need to be taken.

### **Comment #3**

**The Office of Attorney General - Medicaid Fraud Control Unit is not requesting reimbursements for all investigation and prosecution costs from Medicaid providers convicted of fraud as allowed by statute. In addition, the calculation of the prosecution costs is not documented in the case files maintained by the Medicaid Fraud Control Unit.**

Section 191.905, RSMo created the Medicaid Fraud Prosecution Revolving Fund. All of the cost reimbursements awarded by the court attributable to the Medicaid investigation and prosecution are to be paid and deposited in the Medicaid Fraud Prosecution Revolving Fund. Moneys in the Medicaid Fraud Prosecution Revolving Fund may be appropriated to the Attorney General, or to any prosecuting or circuit attorney who has successfully prosecuted an action or violation and been awarded such costs of investigation and prosecution in order to defray the costs of the prosecution. The Office of Attorney General - Medicaid Fraud Control Unit (MFCU) is authorized, through Section 191.905, RSMo, to request reimbursements from the court for investigation and prosecution costs from Medicaid providers convicted

of fraud.

During Oversight's review of case files, two case files were noted that the MFCU had successfully prosecuted and received investigation and prosecution costs. However, the MFCU did not have documentation of the calculation of the costs in the cases. In addition, in two other of the successful prosecutions MFCU did not request any reimbursement of investigation and prosecution costs from the court. Without adequate documentation of time and expenses of attorneys, investigators, and clerical staff, MFCU can not accurately account and justify the costs incurred in a case. Due to lack of documentation, Oversight is not able to determine the amount of reimbursements that should have requested or collected.

Because the MFCU is funded by 75 percent federal funds and 25 percent state general funds, amounts awarded by the courts and recovered from providers that are deposited in the Medicaid Fraud Prosecution Revolving Fund could be used to supplant state general funds or provide match for additional federal funds.

Oversight recommends the Office of Attorney General comply with Section 191.905, RSMo and pursue cost reimbursements from those convicted of Medicaid fraud.

#### **Comment #4**

**The Office of Attorney General is not meeting target collections that were used as a basis for creating the Medicaid Fraud Control Unit.**

As part of Oversight's evaluation of the state Medicaid fraud program, Oversight reviewed House Bill 1427, passed during the 1994 legislative session that established the Medicaid Fraud Control Unit (Unit) within the Office of Attorney General (AGO). Oversight made comparisons of the actual fiscal impact of the establishment of the Unit to the fiscal notes

presented to the General Assembly during the passage of the enabling legislation. In responding to Oversight's fiscal note request during the 1994 session, the AGO estimated that an average of \$10 million (approximately sixty percent federal and forty percent state) would be recouped annually through court cases related to Medicaid payments being received fraudulently. Based upon this assumption, Oversight estimates the total state share that should have been recovered during the evaluation period to be \$20 million. However, the state's share of actual collections by the MFCU during the evaluation period is approximately \$4.2 million of which approximately \$3 million resulted from a national Medicaid settlement in 1994.

The AGO indicated the fiscal note estimate was based on total Medicaid dollars for the state times a projected percentage fraudulent, based on information from other states. The AGO was not able to provide any detailed documentation of the projected fraudulent percentage or any information they had from other states.

As illustrated above, it is difficult and sometimes impossible to predict the fiscal impact of new legislation. However, without necessary documentation being retained to provide an understanding of how and why certain revenue and expenditure estimates were determined in the fiscal note process the General Assembly is not able to make prudent decisions on proposed legislation. Oversight recommends the Office of Attorney General retain documentation of fiscal note estimates.

**Comment #5**

**The Office of Attorney General did not fully staff the Medicaid Fraud Control Unit, possibly resulting in decreased collections and loss of federal matching funds for staff.**

The Office of Attorney General (AGO) requested 23 FTE in the fiscal note to staff the Unit. During Oversight's evaluation, it was noted that there were only 13 FTE positions filled in the Unit. Oversight requested information of staffing patterns within the Unit but was unable to obtain complete information. The General Assembly has appropriated funds to the Unit based on 23 FTE (\$810,516) for fiscal year 1999. For fiscal year 1999 the MFCU lapsed \$264,573 in personal services appropriations. The understaffing of the MFCU has reduced the potential for collections and caused the loss of federal matching funds for staff.

Oversight recommends that the Office of Attorney General fully staff the Medicaid Fraud Control Unit in an effort to improve the timeliness, prosecution, and collections of Medicaid fraud cases.

**Comment #6**

**The Office of Attorney General - Medicaid Fraud Control Unit did not file the 1997 annual report with the Health Care Financing Administration as required by federal regulation.**

As established in federal rules and regulations, 42 CFR 1007.15, the Office of Attorney General - Medicaid Fraud Control Unit (MFCU) is required to submit a report to the Health Care Financing Administration (HCFA) covering the last 12 months at least 60 days prior to the expiration of the certification period. The MFCU apparently did not file the 1997 Annual Report with HCFA in a timely manner. Oversight requested a copy of the annual report during fieldwork and it could not be located. In addition, Oversight contacted HCFA in order to attempt to obtain a copy from their office. HCFA stated they did not have the report on file. As a result, the federal funding for the MFCU could have been jeopardized due to the failure to file the annual report within the required time period.

Subsequent to Oversight's fieldwork, the MFCU filed

the 1997 annual report with HCFA.

Oversight recommends the MFCU file annual reports in a timely manner in order to ensure continued federal funding.

#### **Comment #7**

**The Office of Attorney General is not maximizing federal funding for the Medicaid Fraud Control Unit.**

The Office of Attorney General - Medicaid Fraud Control Unit (MFCU) is funded with federal funds and state general funds. During Oversight's evaluation of the MFCU, it was noted that the MFCU expended state funds of approximately \$306,266 more of the required match for the federal funding in fiscal years 1998 and 1999. The federal/state percentage for fiscal years 1995 and 1996 was 90/10 percent and for subsequent fiscal years 75/25 percent. According to the Office of Attorney General - Fiscal Officer, notification of the federal grant award for the MFCU is not received until after the beginning of the federal fiscal year, usually November or December. As a result, state funds must be expended until the federal funds are available for draw down. However, expenditures are not reviewed prior to fiscal year end to ensure the state matching requirement has not been exceeded. As a result, state general funds in excess of the required match were expended in fiscal years 1995, 1996, 1998 and 1999.

Oversight recommends the Attorney General's Office review MFCU expenditures on a regular basis to ensure the state match requirement is not exceeded. In addition, the AGO should investigate whether amended financial information could be filed to recoup the overspending of state general funds.

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## Chapter 3 - Department of Social Services

### Comment #1

**The Department of Social Services - Division of Medical Services strategic plan does not include any goals, objectives, or mention of a fraud detection and prevention program within the department or division.**

Oversight reviewed the strategic plan for the Department of Social Services - Division of Medical Services (DMS), dated October, 1998 and was unable to find in the strategic plan any goals, objectives, or mention of a fraud detection and prevention program within DMS. Because of this lack of inclusion in a strategic plan, there is no framework within DMS to heighten accountability for the detection and prevention of fraud in the state Medicaid program. The framework should be included in a strategic plan that would identify weaknesses in current program operations, integrate fraud-fighting activities, and close gaps that permit inappropriate payments. Oversight discussed with DMS staff the lack of any goals, objectives, or mention of a fraud detection and prevention program within the strategic plan. The staff could not determine why there was no inclusion in the strategic plan.

Oversight recommends that DMS develop an overall framework to heighten accountability for fraud detection and prevention in the state Medicaid program. The framework should include strategies that identify weaknesses in current program operations, integrates fraud and abuse fighting activities, and closes gaps that permit inappropriate payments. In addition, this framework should be updated annually to reflect changing trends in the detection and prevention of fraud.

**Comment #2**

**The Department of Social Services - Division of Medical Services requested and received funding for five additional FTE to assist the Medicaid Fraud Control Unit in the Attorney General's Office but has not filled two of the positions.**

Oversight reviewed the fiscal note request prepared by the Department of Social Services - Division of Medical Services (DMS) for House Bill 1427 from the 1994 legislative session. In the fiscal note request DMS assumed that it would need five additional full-time equivalent positions (FTE) to assist the Medicaid Fraud Control Unit (MFCU) in the Office of Attorney General by making referrals to the MFCU, researching and retrieving documents from the Medicaid Management Information System (MMIS), testifying in court on Medicaid fraud cases, and attending regular meetings concerning pending cases with the MFCU.

Oversight also reviewed DMS's budget requests for fiscal years 1995 thru 1999. During the review and from discussions with DMS - Budget and Planning and DMS - Human Resource personnel it appears that 2 of the five positions were never filled even though the legislature funded these positions. DMS has not fully utilized the funding received for personal services and the corresponding expense and equipment as originally requested.

Oversight recommends that the General Assembly, through the budget and appropriations staff, determine the status for the funding of the positions in regard to appropriations or reduce DMS's core budget by the two positions and corresponding expense and equipment.

**Comment #3**

**The Division of Medical Services - Surveillance and Utilization Review Unit may not be adequately trained in fraud prevention and detection.**

According to federal regulations, Chap. 42 CFR 432.30, a state Medicaid plan must provide for a program of training for Medicaid agency personnel. The training should include initial in-service training for newly appointed staff and continuing training opportunities to improve the operation of the program.

During Oversight's review of the operations of the Department of Social Services - Division of Medical Services - Surveillance and Utilization Review Unit (SURS) it was noted that the department is not effectively training new staff hires or providing continuing education to current staff. By not providing effective and timely training, the SURS may not have fully complied with federal regulations which state that on-going training in fraud detection or prevention should be provided to the SURS unit. SURS has a staff of fifteen people. The staff consists of six medicaid technicians, three medicaid specialists, two registered nurses, one physician, two support staff and one unit supervisor.

Oversight recommends that the Department of Social Services, Division of Medical Services provide training in fraud detection and prevention for the SURS unit. Such training could increase the overall effectiveness of the staff and enhance the unit's ability to detect potential fraud. Through attrition, DOS should consider hiring more experienced and trained staff, such as certified fraud examiners, to further increase the effectiveness of the SURS unit in the prevention and detection of fraud.

**Comment #4**

**The Missouri Medicaid Program could be using resources more effectively in the detection and prevention of fraud.**

During Oversight's review of the Medicaid Program, it was determined that the program has not undertaken a comprehensive, system-wide evaluation of its resources committed to fighting fraud. These resources include the fiscal intermediary GTE, the Missouri Patient Care Review, the Office of Attorney General - Medicaid Fraud Control Unit, and the Department of Social Services - Division of Medical Services monitoring staff, among others. As part of its strategic plan, the Medicaid program needs to evaluate how its resources are deployed, determine whether resources should be redistributed to increase their fraud- and abuse-fighting potential, and whether additional resources are needed.

In the past, the Medicaid program has reviewed its resource requirements for fraud-fighting activities on an ad hoc, as needed basis. Department staff note that they have looked for creative ways to use staff more efficiently and made efforts to obtain additional resources with little or no impact on state general funds. Oversight believes the program should expand these efforts through a broad, system-wide resource analysis through the following:

First, Oversight believes the program should consider the feasibility of reallocating current state dollars to leverage additional federal funds for intensifying oversight of fraud and abuse. For example, the Medicaid Fraud Control Unit (MFCU) is funded by 75 percent federal funds and 25 percent state general funds. Additionally, services performed by contract through the Department's Peer Review Organization, Missouri Patient Care Review Foundation (MPCRF), are also funded by 75 percent federal funds. Effective in October of 1999, most Medicaid functions and services will be funded by 50 percent federal funds and 50 percent state general funds. If the Medicaid program identifies resources in one area that could be reallocated to intensify fraud-fighting activities - such as taking dollars from programs funded by

a higher percentage of state general funds and using them to fund fraud investigators or nurse claims reviewers - it could bring in significantly more federal funds. For example, under most Medicaid functions and services, \$50 in general funds brings in \$50 in federal funds. By applying the same general funds to nurse claims reviewers or fraud investigators, \$50 brings in \$150 in federal funds or three times the previous amount. Similarly, by replacing program activities that receive a \$50-to-\$50 match rate with activities that can be appropriately contracted through MPCRF, the Medicaid program can receive \$150 for the same \$50 general fund contribution. To increase federal funds and retain the original general fund appropriation, the Medicaid program requires the approval of the General Assembly through the appropriation process. With the General Assembly's approval, this is one way the Medicaid program could expand the resources available for investigating and prosecuting fraud and abuse without increasing the state general funds required to do so.

Secondly, the Department may also need to determine if additional resources are required in some areas to provide appropriate levels of oversight, curtail abusive practices, and increase recoveries. If so, the Department should conduct an appropriate workload analysis to substantiate its need for resources and develop a plan for acquiring them. A comprehensive plan addressing the acquisition and distribution of resources is key to ensuring adequate resources are available and committed to curtailing fraud and abuse.

Oversight recommends the Department of Social Services should, in conjunction with the Medicaid Fraud Control Unit and any other appropriate agencies, undertake a comprehensive evaluation of the distribution of statewide resources dedicated to curtailing fraud and abuse. The evaluation should:

1. Investigate the feasibility of leveraging current state general funds to obtain additional federal funds for qualified fraud-fighting activities.

2. Result in a plan for redistributing resources and, if necessary, acquiring additional resources to intensify fraud-fighting efforts.

Additionally, the Department should seek the approval of the General Assembly for federal fund leveraging through the appropriation process.

#### **Comment #5**

**The Department of Social Services - Division of Budget and Finance is not depositing Medicaid restitution receipts and prosecution cost reimbursements received from court cases into the appropriate funds.**

The Department of Social Services (DOS) - Division of Budget and Finance is not depositing Medicaid restitution and prosecution cost reimbursements into the proper funds. DOS is depositing Medicaid restitution and prosecution cost reimbursements received from cases involving the Office of Attorney General (AGO) - Medicaid Fraud Control Unit (MFCU) into the state General Revenue Fund and the Title 19 Federal and Other Funds. The AGO sends the checks to the Department of Social Services - Division of Budget and Finance with a memo stating the funds were collected pursuant to statute.

Section 191.905, RSMo created the Medicaid Fraud Reimbursement Fund and the Medicaid Fraud Prosecution Revolving Fund. Medicaid restitution received from court cases is to be deposited into the Medicaid Fraud Reimbursement Fund, and investigation and prosecution cost reimbursements are to be deposited into the Medicaid Fraud Prosecution Revolving Fund. Moneys deposited into the Medicaid Fraud Reimbursement Fund are to be divided and appropriated to the federal government and affected state agencies in order to refund moneys falsely obtained from the federal and state governments. Funds in the Medicaid Fraud Prosecution Revolving Fund may be appropriated to the attorney general or to any prosecuting or circuit attorney who has successfully prosecuted an action and has been awarded

costs of prosecution. These amounts are to defray the costs incurred by the attorney general or any prosecuting or circuit attorney in connection with their duties as provided by Section 191.900 through 191.910, RSMo.

By not depositing Medicaid fraud restitutions and prosecution cost reimbursements into the established funds, there is no clear accounting of amounts received. The depositing into the proper fund would help establish a performance measurement for the operations of the MFCU. In addition, by not depositing the receipts into the proper funds annual appropriation review by the General Assembly is not possible.

Oversight recommends the General Assembly encourage the Office of Attorney General - Medicaid Fraud Control Unit (MFCU) and the Department of Social Services - Division of Budget and Finance to use the proper funds that the General Assembly has established for restitutions and prosecution reimbursements from the successful prosecution of Medicaid fraud cases.

#### **Comment #6**

**The Division of Medical Services is not effectively meeting the expectations of the Medicaid Fraud Program because it has not actively pursued the recovery of inappropriate payments.**

The Department of Social Services (DOS) - Division of Medical Services (DMS) - Surveillance and Utilization Review Unit (SURS) reviews payments to Medicaid providers to determine if overpayments have been made. The SURS Unit subsequently determines if the amount of overpayment (accounts receivable) is collectible or uncollectible. According to the SURS unit reasons for uncollectible overpayments are that a provider may go out of business, file bankruptcy, or receive a settlement agreement of a Administrative Hearing Commission appeal. As for the rest of the uncollectible overpayments, cases are referred to the DOS - Division of Legal Services for further collection action. Oversight reviewed the accounts receivable report generated by the cash control section through June 30, 1999. The total accounts

receivable outstanding was \$2,575,441. Of that amount, \$1,575,865 (61%) was determined to be uncollectible by SURS based on a review of the accounts. Based on the review of accounts approximately \$429,250 of the accounts receivable was referred to the Division of Legal Services for further action.

Significant staff resources are required to pursue recoveries in neglected areas, especially if the payments are several years old. Both the Medicaid program and the MFCU believe they lack staff for an effort of this magnitude. Under a contingent fee arrangement, the State hires an outside contractor to pursue recoveries. The State receives the benefit of additional recoveries without hiring additional staff. The arrangement is budget-neutral because the contractor is paid a percentage of the recovery and receives payment only if the recovery is successful.

The Medicaid program should consider its use of contingent fee arrangements to detect and recover inappropriate payments. However, additional work is needed to identify the areas where expansion is most appropriate. Under a contingent fee arrangement, the Medicaid program would contract with a firm to pursue a recovery and the contractor receives a percentage of the actual recovery as its fee.

Oversight also recommends that the Department of Social Services - Division of Medical Services be more pursuant through the judicial system of overpayment of Medicaid funds to providers. Obtaining civil judgments against providers would possibly allow for recoveries against firm or personal assets for overpayments.

## APPENDIX 1

						APPENDIX 1
Schedule of Medicaid Expenditures						
6 Years Ending June 30, 1999						
	1999	1998	1997	1996	1995	1994
Nursing Facilities	\$715,053,894.89	\$699,583,350.26	\$633,862,789.47	\$574,784,654.77	\$492,866,370.95	\$442,282,097.86
Hospitals	\$518,471,036.60	\$438,174,510.73	\$429,842,402.74	\$50,132,960.76	\$594,942,837.22	\$552,742,425.63
Dental Services	\$6,039,292.86	\$8,384,327.77	\$10,873,596.89	\$13,255,070.48	\$16,413,578.22	\$15,968,944.64
Pharmacy	\$468,598,432.43	\$374,086,932.53	\$320,821,306.58	\$285,069,051.22	\$261,802,883.33	\$227,435,397.16
Physician Related	\$142,998,872.20	\$125,039,701.10	\$130,860,077.96	\$150,281,276.20	\$162,681,243.72	\$158,248,529.47
In-Home Services	\$160,785,429.32	\$142,395,340.43	\$121,883,531.07	\$102,979,238.46	\$84,645,142.84	\$60,304,592.46
Other Services	\$59,764,713.53	\$46,236,831.18	\$43,565,476.36	\$41,664,237.84	\$37,954,300.31	\$32,982,044.86
Buy-in Premiums	\$49,113,672.70	\$46,433,023.80	\$44,804,302.20	\$43,479,207.50	\$40,839,255.10	\$34,278,539.40
Mental Health Services	\$241,910,745.70	\$216,884,903.54	\$199,538,318.65	\$185,985,093.97	\$162,351,288.24	\$124,141,208.84
State Institutions	\$136,813,413.86	\$133,704,239.12	\$140,938,555.26	\$142,907,683.96	\$135,590,978.62	\$135,377,291.39
EPSDT Services	\$89,218,520.24	\$70,064,457.67	\$72,218,947.53	\$82,097,948.64	\$82,412,684.50	\$54,227,683.62
Managed Care	\$307,342,648.32	\$51,044,813.26	\$11,013,243.01	\$24,531,389.22	\$27,421,601.60	\$14,870,859.09
	\$2,896,110,672.65	\$2,352,032,431.39	\$2,160,222,547.72	\$1,697,167,813.02	\$2,099,922,164.65	\$1,852,859,614.42

## APPENDIX 2

						APPENDIX 2
Schedule of Medicaid Recipients						
6 Years Ending June 30, 1999						
	1999	1998	1997	1996	1995	1994
Nursing Facilities	314,336	316,596	316,663	316,983	316,531	316,006
Hospitals	828,912	719,822	788,343	927,774	1,104,397	1,032,736
Dental Services	89,910	128,304	162,521	205,521	255,460	247,249
Pharmacy	2,243,717	2,071,567	2,177,239	2,436,987	2,672,963	2,536,887
Physician Related	1,580,602	1,519,360	1,626,531	1,870,989	2,018,401	2,121,549
In-Home Services	333,027	306,471	280,373	258,476	222,569	160,424
Other Services	353,284	284,316	276,083	282,645	282,773	247,723
Buy-in Premiums	1,012,002	981,161	954,172	911,066	861,982	809,238
Mental Health Services	156,266	136,216	121,712	116,102	100,710	66,218
State Institutions	191,538	159,416	184,252	167,969	161,232	139,641
EPSDT Services	591,540	474,039	585,563	767,101	848,970	569,539
Managed Care	3,131,365	570,061	39,545	96,110	106,787	62,504
	10,826,499	7,667,329	7,512,997	8,357,723	8,952,775	8,309,714

## APPENDIX 3

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JAN 13 2000

OVERSIGHT DIVISION



ATTORNEY GENERAL OF MISSOURI

JEREMIAH W. (JAY) NIXON  
ATTORNEY GENERAL

JEFFERSON CITY  
65102

P.O. Box 899  
(573) 751-3321

January 13, 2000

The Honorable Robert M. Clayton  
Chairman of the Joint Committee on Legislative Research  
Room 114-C, Capitol Building  
Jefferson City, MO 65101

Dear Representative Clayton:

I am pleased to report that the Office of the Attorney General has completed a review of the Legislative Oversight Committee's report on the operations of the Medicaid Fraud Control Unit. The recommendations and changes suggested by the committee staff will help improve the efficiency of the unit.

I commend Jeanne Jarrett, Director of the Oversight Division, and her staff for a thorough and professional review. The process has been informative and instructive for our staff and the citizens of Missouri will be better served because of these efforts.

I appreciate the wisdom of the state legislature for authorizing this program in 1995 and for their continued support. Despite some of the challenges associated with the startup of this significant effort in Missouri, the work of the Medicaid Fraud Control Unit is essential if we are to protect Medicaid from fraud and to protect those who can least protect themselves from abuse.

We will continue to meet this important challenge and I am confident the citizens of Missouri will benefit from the analysis and recommendations of the Oversight Committee. Please note the attached comments which provide additional information relevant to the operation of the unit.

Sincerely,

Jeremiah W. (Jay) Nixon

cc: Jeanne Jarrett, CPA

**Comment #1:**

The memorandum of understanding (MOU) requires that all referrals be reviewed within 90 days. A new system was developed following the January 1999 restructuring of the MFCU and the unit currently exceeds this requirement by concluding its preliminary review of all referrals from the Division of Medical Services-Surveillance Utilization Review Unit (SURS) within 14 days. Currently, if the MFCU chief investigator, in consultation with the director, determines a complaint to be meritorious, the matter is assigned to a staff attorney who supervises further investigation into the allegations. This system allows for accelerated reviews of new referrals and effective allocation of investigative and prosecutorial resources.

The review process has always been prioritized based on the nature of the referral with the most serious referrals investigated first. This system continues but our reorganization allows for a more expedited review of all referrals.

**Comment #2:**

The MFCU and SURS regularly communicate on the status of referrals. At the inception of the MFCU, monthly meetings were part of a mutually agreed upon protocol. However, that protocol has been modified by the parties to its current status. The MFCU will review with SURS the current system to determine whether procedural adjustments are necessary and, if appropriate, the MOU will be amended.

The MFCU attempts to coordinate with DOSS on issues relating to the seeking of overpayment reimbursements from providers. As a general matter, DOSS will not request overpayment reimbursement from a provider for 30 days after making a referral to the MFCU. Thereafter, actions to collect overpayments from providers are instituted. The MFCU will continue to communicate with DOSS on the status of active investigations so as to maximize the recovery of identifiable overpayments.

The MFCU is unaware of any provision in state law that allows or requires DOSS to stop payment to providers simply on the basis that fraud is suspected. MFCU understands that Medicaid payments to providers will only cease upon a conviction or in instances of specific overpayments.

**Comment #3:**

The primary purpose of the MFCU is to prosecute fraud in the Medicaid system and to prosecute abuse and neglect in the nursing home setting. Upon receiving a conviction or resolution in a Medicaid fraud case, the MFCU first attempts to maximize the amount of restitution going back into the Medicaid program to fund the health care needs of Missourians. Then, if any additional money is available from the criminal defendant, it can be used for the cost of the investigation and prosecution. In 1999, the MFCU has incorporated the payment of investigative and prosecution costs into some plea agreements and will seek to do so more in the future.

**Comment #4:**

The MFCU must aggressively prosecute all fraud in the Medicaid system regardless of the dollar amounts involved. Each case serves as a deterrent to other providers. However, the MFCU's efforts to maximize recovery are impacted by a number of issues. First, the largest recoveries are obtained in cases of institutional fraud. However, the MFCU has received very few referrals related to institutional fraud. The MFCU has, in part, addressed this issue, by having two (2) attorneys cross-designated Special Assistant United States Attorneys who work in conjunction with the United States Attorney's Office in the Eastern District on federal referrals of cases involving institutional fraud.

Second, the transition from fee-for-service to managed care plans has changed the way services are provided and how the Medicaid program is billed. In a fee-for-service system, providers bill the state for the services they provide. This permits direct access to the billing documentation and allows a more thorough review and analysis of the billing patterns of the providers. By contrast, in managed care plans, data submitted to the state is frequently incomplete. This has the potential of creating barriers to fraud detection. The MFCU has dealt with this shift by being proactive in the identification of areas of fraud in the managed care system. Most notably, the MFCU has recently initiated civil suits against two HMOs for failing to provide lead testing for children.

Lastly, the U.S. Department of Health and Human Services, Office of Inspector General (OIG), has traditionally discouraged state MFCUs from using civil remedies. This has limited the MFCUs ability to maximize recoveries. In 1999, recognizing this limitation decreases our effectiveness in addressing fraud in the Medicaid program, the MFCU began greater utilization of its civil remedies. In February 1999, the MFCU received national attention when it filed suit seeking double damages against a speech pathologist and simultaneously seized expensive automobiles and other assets, froze bank accounts and attached the home. In December 1999, OIG issued a memorandum relaxing its position on state MFCU's use of civil actions.

The changes implemented by the MFCU in 1999 has paid immediate dividends. For the year, the MFCU obtained restitution orders and settlements totaling \$1,997,963.20 in state and federal dollars.

**Comment #5:**

The MFCU was not fully staffed during fiscal year 1999, due in part to the restructuring previously discussed. However, other than periods of turnover in personnel, the MFCU has historically operated near full capacity.

**Comment #6:**

The MFCU agrees with this comment and has confirmed with the Department of Health and Human Services-Office of Inspector General that all required reports are on file.

**Comment #7:**

The MFCU generally receives notification of the federal grant award 45-60 days after the start of the federal fiscal year. As a result, it has been necessary for the AGO to use state funds to operate the MFCU at the beginning of the federal fiscal year. The AGO will investigate whether amended financial information can be filed to recoup state general funds.



MEL CARNAHAN  
GOVERNOR

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DEPARTMENT OF SOCIAL SERVICES  
DIVISION OF MEDICAL SERVICES

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JAN 12 2000

OVERSIGHT DIVISION

January 11, 2000

Ms. Jeanne Jarrett, CPA, Director  
Oversight Division  
Room 132, State Capitol  
Jefferson City, MO 65101-6806

Dear Ms. Jarrett:

Enclosed are the Department of Social Services, Division of Medical Services, responses to comments included in the program evaluation report on the State of Missouri's efforts to combat Medicaid fraud.

Please contact Marga Reinsch at 573/751-1092 if you have any questions regarding these comments.

Sincerely,

A handwritten signature in black ink, appearing to read "Gregory A. Vadner".

Gregory A. Vadner  
Director

GAV:kl

Enclosure

**Comment 1.** The Department of Social Services - Division of Medical Services strategic plan does not include any goals, objectives, or mention of a fraud detection and prevention program within the department or division.

**Response:** Even though there is not a direct reference to fraud detection and prevention in the strategic plan, the issue is indirectly addressed under the goal of providing "more cost effective use of taxpayer money." The Medicaid Fraud and Abuse Compliance program, with its focus upon fraud and abuse processes, meets this strategic goal. That program does have clear objectives spelled out.

We agree that a direct reference to fraud detection and prevention within the strategic plan is appropriate. We will include in the next strategic plan strategies that will specifically focus on DMS responsibilities relating to fraud detection and prevention.

**Comment 2.** The Department of Social Services - Division of Medical Services requested and received funding for five additional FTE to assist the Medicaid Fraud Control Unit in the Attorney General's Office but has not filled two of the positions.

**Response:** For FY 95, the department requested five FTE for the Surveillance and Utilization Review Services (SURS) unit to support the Attorney General's Medicaid Fraud unit. The FTE were added on a separate line within the appropriations bill as a one-time expense. For FY 96, funding was continued for four of the FTE but funding was removed, via a core cut, for one of the FTE that was added in the prior year.

DMS agrees that we currently cannot identify the remaining FTE as being specifically assigned full-time to fraud detection and prevention activities. Instead, there are many staff that perform fraud prevention and detection activities as part of their daily routine. There are 15 staff within the SURS unit who perform preventive procedures to avoid fraud and abuse, detect abnormal patterns, and refer potential fraud to the Attorney General's Office. In addition, DMS has 18 staff in the Quality Assessment unit and 9 staff from the Pharmacy and Exceptions unit that play critical roles for the division in the prevention of fraud by continuously monitoring, reviewing, and evaluating provider practices. Through maximizing the use of the fourth FTE dollars by spreading it throughout many positions, the division support for SURS related activities far exceeds that gained by a single FTE.

**Comment 3.** The Division of Medical Services - Surveillance and Utilization Review Unit may not be adequately trained in fraud prevention and detection.

**Response:** DMS recognizes the importance of training, especially in the always changing environment of Medicaid fraud and abuse, and will look for additional training opportunities to enhance the skills of SURS staff. The division is in compliance with federal regulations relating to training. The federal regulations require the division to provide initial training for new hires and ongoing educational opportunities. The division provides the following training opportunities for SURS staff:

- On the Job Training. New hires are assigned to an experienced staff member for on the job training for a period of six months. This training is very effective and efficient.
- Training sessions offered by the Attorney General's Office
- Training sessions and seminars provided by the Health Care Financing Administration Medicare/Medicaid Fraud and Abuse
- Attendance at the annual SURS conference

The expertise of the staff has been recognized. SURS staff have participated in the Health Care Financing Administration (HCFA) workgroups regarding fraud and abuse. Three staff have received recognition for assisting in the development of documents for a national initiative regarding fraud and abuse. HCFA acknowledged the input of SURS staff regarding the Medicaid Fraud and Abuse National Initiative. The agency provided certificates of appreciation for their contribution to the development of the publication "Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care."

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Page 4

**Comment 4.** The Missouri Medicaid Program could be using resources more effectively in the detection and prevention of fraud.

**Response:** DMS agrees to explore enhanced federal matching opportunities for fraud and abuse prevention activities. This effort should also include looking at non-DMS resources in the state that may be eligible for an enhanced federal match.

**Comment 5.** The Department of Social Services - Division of Budget and Finance is not depositing Medicaid restitution receipts and prosecution cost reimbursements received from court cases into the appropriate funds.

**Response:** Section 191.905 did establish a Medicaid fraud reimbursement account and further states that the full recovery be deposited to the account and then "divided and appropriated to the federal" and state agency. In order to make a timely transfer of these funds to the appropriate federal and state accounts, the Division of Budget and Finance uses the long established procedures in which 60.5% is deposited directly to the federal account and 39.5% is deposited to a refund of general revenue. The result of current procedures is that the recovered funds are deposited in the manner the statute ultimately provides. To deposit first into a Medicaid Fraud Reimbursement account will add another step in the process and require appropriation authority for a transfer from that fund to General Revenue and Medicaid federal funds. We will also need to work closely with the Attorney General to assure that restitution which results from a conviction are specifically identified so they can be correctly deposited.

**Comment 6.** The Division of Medical services is not effectively meeting the expectations of the Medicaid Fraud Program because it has not actively pursued the recovery of inappropriate payments.

**Response:** DMS disagrees. DMS has effectively met Medicaid Fraud Program expectations and has actively pursued the recovery of inappropriate payments. SURS staff pursue recovery of overpayments for all cases of suspected abuse, abuse, and potential fraud. Providers who are suspected of abuse undergo a prepayment review process of all billings. This action immediately reduces the incidence of overpayments. Overpayments due DMS are withheld from any future payments to the provider.

DMS agrees that it takes significant resources to investigate cases of potential fraud and abuse. We are, however, cautiously reviewing the use of contingency contracts. Due to the nature of contingency based contracts, contractors are rewarded only if they make recoveries. These kinds of contracts are detrimental to the Medicaid program if the contractor harasses providers. These types of contractors can limit access to health care for Medicaid recipients. DMS has two units, SURS and Third Party Liability, that may in fact be investigating the same cases that the contractor would uncover. The division does not wish to be put in the position of paying a contractor for overpayments that state staff have identified and are currently investigating. This is in fact what often actually happens in these types of contracts. Contingency contracts are also administratively burdensome since division staff must review, investigate, and often carry out all of the due process work in pursuing many of the cases identified by the contractor.

In response to the final comment relating to the division's efforts in pursuing civil judgments against providers, DMS forwards potential civil cases to the Division of Legal Services when DMS is unsuccessful in collecting overpayments. The department pursues, and will continue to pursue, these civil cases when it is financially beneficial to the state.

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Page 7

**Comment 7.** The Office of Attorney General - Medicaid Fraud Control Unit closed referrals for further investigation but were not referred back to the Department of Social Services - Division of Medical Services - Surveillance Utilization Review Unit for review and follow-up for any overpayment or billing mistakes.

**Response:** DMS will encourage enhanced communication between the Attorney General - Medicaid Fraud Control Unit and the SURS unit. DMS will review the Memorandum of Understanding with the Attorney General Medicaid Fraud Control Unit to ensure those closed cases are properly referred back for handling.

